

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005113	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/24/2013
NAME OF PROVIDER OR SUPPLIER KOSCIUSKO COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00126435 Substantiated: No deficiencies cited</p> <p>Date: 7/24/13</p> <p>Facility Number: 005113</p> <p>Surveyor: Linda Plummer. R.N., Public Health Nurse Surveyor</p> <p>Kosciusko Community Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Services and 410 IAC 15-1.6.2, Emergency Services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 07/30/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE